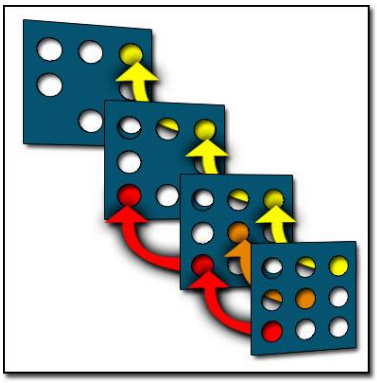
SAMPLE

RISK MANAGEMENT PLAN (RMP)



FACILITY X (Name and Logo)

800 MAIN STREET

HOMETOWN, KANSAS 65432

****Update**** indicates areas that are typically needing updating every year.

Please note that the RMP in its entirety is to be submitted to KDHE for initial approval and annually for subsequent approval maintenance.

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RISK MANAGEMENT PROGRAM***Update***

Facility name and address and contact information

Committee member names and titles and contact information

Risk Manager's name and title and contact information

APPROVAL PAGE****Update****

Plan approval signatures: Facility Board Representative, Administrator, Chief of Medical Staff, Risk Manager

Appendices

A – Organizational Chart, indicating the position of the facility's review committee (required) ****Update****

B – Occurrence/Incident Report Form

C – Log

D – Investigational Tool

E – Grounds for Disciplinary Action/Professional Codes

F –Report Forms

G- RM Resources (to include things like Regulatory Boards with contact information) and other resources and information.

Revision History ****Update****

This Risk Management Plan (RMP) is reviewed, updated and approved as necessary and no less than annually. The approved RMP in its entirety is then submitted to the KDHE Risk Manager to be maintained on file.

Risk Management Plan/ Contents	Status	Date	Page/ Section Content Update	Owner	KDHE Submission
Initial Version	Approved by RM Committee	xx/xx/xx	Entire RMP	Risk Manager	Completed and Approved.
Annual Review and Approval	Approved by RM Committee	Xx/xx/xx		Risk Manager/ Committee	Completed and Approved.

I PURPOSE

The risk management program of FACILITY X is designed to assure that the standard of care by the staff is maintained at the acceptable level, to reduce the risk of patient injury as a consequence of that care, and to minimize financial loss to the facility.

II Objectives and Statutes/ Regulations

The risk management program is designed to:

1) Identify areas of risk in the clinical aspects of patient care and safety
2) Identify criteria for screening assess with risk potential regarding clinical aspects of patient care and safety
3) Establish the investigative and evaluative process applied to cases with risk potential
4) Assure timely intervention in events below standard of practice
5) Develop policies and programs to reduce risk in clinical aspects of patient care and safety
6) Establish communication between risk management and quality assurance/improvement functions in the facility
7) Report risk management activities to the Kansas Department of Health and Environment and other appropriate licensing agencies, as mandated by law

III GOVERNING BODY AUTHORITY

The governing board duly authorizes the Risk Management Committee and the Medical Staff Executive Committee* as the committees which are responsible for investigating and determining applicable standards of care as required by state risk management laws, KSA 65-4921 et seq. These committees are established for the purposes of compliance with the risk management statutes; to evaluate and improve the quality of health care services and peer review act found at KSA 65-4915(a)(3). The governing board has the final responsibility and authority for the risk management program of FACILTY X.

This plan was developed in accordance with provisions of the aforementioned Kansas statutes. Responsibility for implementation of this plan is delegated to the Risk Manager.

*Larger facilities may find it appropriate to establish more than two committees while the smaller facilities may need only one committee. Those facilities that have one committee should ensure that the committee is multi-disciplinary, such as: two physicians, two registered nurses, a representative from ancillary services etc. Appropriate consulting physicians may also be appointed to this committee.

IV REPORTING OCCURRENCES/INCIDENTS

In accordance with KSA 65-4921 et seq, all employees, health care providers, and medical care facility agents are required to report any “reportable incident” to the risk manager, the chief administrative officer, and/or the chief of medical staff. KSA 65-4921(f) defines the term “reportable incident” as:

> An act by a health care provider which: (1) is or may be below the applicable standard of care and has a reasonable probability of causing injury to a patient; or (2) may be grounds for disciplinary action by the appropriate licensing agency.

Health care providers who are subject to statutory risk management include: medical care facilities, doctors of medicine/osteopathy, chiropractors, optometrist, podiatrist, pharmacists, dentists, licensed dental hygienists, physical therapist, physical therapy assistants, occupational therapist, occupational

therapy assistants, respiratory therapists, radiology technologists, athletic trainers, naturopathic doctors, registered nurses, licensed practical nurses, mental health technicians, psychologists, social workers, and professional counselors.

Per KSA 65-4927(c), the willful failure of a healthcare providers and/or medical care facility employee to report, as required by law, is punishable as a Class C misdemeanor.

When a reportable incident is identified, the person with knowledge of the incident completes the reporting form for the risk management program (Appendix B). These forms are available to staff in each department of the facility. All reportable incidents are to be reported to the risk manager within 24 hours of discovery. Upon receipt of an incident report, the risk manager will enter the case in the risk management log (Appendix C) for tracking through its completion.

Identification of reportable incidents may be generated by, but not limited to the following method:

1) Personal Observations
2) Occurrence Screens
3) Infection Control Reports
4) Complication Reports
5) Death Reviews
6) Blood Usage Reviews
7) Tissue Reviews
8) Patient Satisfaction Surveys
9) Patient/Family Complaints
10) Medical Record Reviews

The risk manager shall have the authority to review all facility and medical policies, procedures, records, committee minutes and actions, to make recommendations to administration and the medical staff, and to initiate independent investigations to bring cases to satisfactory closure.

Category Types on the Reporting Form includes:

□ Fall □ Abuse, Neglect or Exploitation □ Assessment/treatment □ Professional licensure event □ Delay □ Facility process or system-related □ Scope of Practice □ Impairment due to drug, alcohol or cognition □ Falsification □ Documentation of Narcotics □ Medication Error □ Improper Procedure □ EMTALA-Related □ IV line mix-up □ Drug Diversion □ Unprofessional conduct □ IV infiltration

□ Other: _____

Per KSA 65-4924: Impaired providers; if a report to a state licensing agency pursuant to subsection (a)(1) of (2) of KSA 1986 Supp. 65-4923 or any other report or complaint filed with such agency relates to a health care provider's ability to practice the provider's profession with reasonable skill and safety due to physical or mental disabilities, including deterioration through the aging process, loss of motor skill or abuse of drugs or alcohol, the agency may refer the matter to an impaired provider committee of the appropriate state or county professional society or organization.

V INVESTIGATION OF OCCURRENCES

All clinical variance/incident reports will be investigated by the risk manager or the appropriate department director/designee and will result in a specific standard of care determination. Separate standard of care determinations shall be made for each involved provider and each clinical issue reasonably presented by the facts. Resulting conclusions for standard of care determinations will be documented on the investigational tool (Appendix D). The primary reviewer must sign and date the investigational tool. Preliminary standard of care determinations are recorded on the risk management log.

VI DULY AUTHORIZED RISK MANAGEMENT COMMITTEES

Results of the investigation are presented to the appropriate committee for final standard of care determination. All reviewers and committees shall be considered peer review committees pursuant to the provisions of KSA 65-4915.

The RMC (Risk Management Committee) functions as the nursing/ancillary staff peer review/risk management committee. Members include department heads from ancillary services, outpatient and nursing; quality improvement director; the risk manager; and the administrator. The risk manager is the chairperson.

The MSEC (Medical Staff Executive Committee) functions as the physician/credentialed practitioner peer review/risk management committee. It is composed of directors for surgery, anesthesiology, obstetrics and emergency departments. The Chief of Medical Staff is the chairperson. Non-voting members include the health information director and the risk manager. Names and titles of all medical staff involved with risk management peer review are included on the signature page.

With respect to each reported incident. The committees must determine: (1) whether individual health care providers met applicable standards of care expected in the facility; (2) if not, whether failure to meet those standards caused injury or had a reasonable probability of causing injury to a patient; and (3) whether any action by a health care provider might be grounds for disciplinary proceedings by the appropriate licensing agency. A list of the acts (Appendix E) which are grounds for disciplinary action by a health care provider licensing board is available to the risk management committees and all health care providers, facility employees and facility agents through the office of Risk Management.

The activities of each risk management committee shall be documented in its minutes. Meetings are held at least quarterly. The meeting minutes demonstrate that the committee is exercising overall responsibility for finalization of all standard of care determinations. All standard of care 1 and 2 determinations, made by individual clinicians or subordinate committees shall be approved by the designated risk management committee on at least a statistical basis. This approval will be documented in the risk management committee minutes.

The minutes of the foregoing committees shall, also, document a specific standard of care determination along with conclusions/rationale for all incidents with standard of care determinations of 3 and 4. Additionally, the minutes will document all incidents for which the standard of care has been changed by the duly constituted committee and rationale for the change. Standard of care determinations are recorded in the log.

The risk management committees may call upon the expertise of any facility personnel or medical staff member in fulfilling their functions. All facility personnel, administration, and medical staff members shall be obligated to cooperate with the risk management committees in acknowledgement of the joint responsibility of the medical staff, facility personnel, and administration for risk management pursuant to Kansas law.

Quality review-contractors/consults; all patient services including those services provided by outside contractors or consultants shall be periodically reviewed and evaluated in accordance with the plan.

(Please specify how this review is accomplished in your facility).

The risk manager shall have the responsibility for filing quarterly reports (Appendix F) with the Kansas Department of Health and Environment and reportable finding reports with the appropriate state licensing agencies. **The risk manager is also responsible for notifying the provider when a reportable finding has been reported to their licensing agency.**

Remediation and reporting includes determining the corrective action taken such as:

□ Policy / Procedure Change □ Suspension of Privileges □Termination □ Counseling / Education
□Restriction of Privileges □ Revocation of Privileges □ Pending □ Other: _____

VII STANDARD OF CARE DETERMINATIONS

Each facility shall assure that analysis of patient care incidents complies with the definition of a "reportable incident" per KSA 65-4921(f). This facility shall use the following categories:

(1) Standards of care met

(2) Standards of care not met, but with no reasonable probability of causing injury

(3) Standards of care not met, with injury occurring or reasonably probable*

(4) Possible grounds for disciplinary action by the appropriate licensing agency*

*Categories 3 and 4 are reportable findings and by law must be reported to the appropriate licensing agency. All must be reported to KDHE and in addition, any applicable licensing agency involved such as Kansas Board of Nursing, Board of Healing Arts, et al.

VIII QAPI and Minimizing Occurrences

Facility X has established the following mechanisms to minimize occurrences:

A **Education:** All new employees will receive information mandating their obligation to report reportable incidents to the risk manager. The purposes of risk management and how to report in this facility will also be explained. The Risk Management plan will be reviewed at this time. Each employee will receive risk management in service on an annual basis, thereafter. A copy of the Risk Management plan and a printed handout explaining the risk management law will be provided to each medical staff member and each board member at the time of appointment and annually, thereafter. Any time the plan is amended, medical staff members, employees, and governing board members will be informed of the changes.

B **Credentialing and Performance Evaluation:** All Standard of Care determinations will be applied to medical staff credentialing and employee performance evaluation. In addition, reportable findings will be reported to the appropriate licensing agency.

C **Monitoring Frequency:** Data relevant to reported variances/incidents will be compiled by the risk manager in a statistical summary and will be presented quarterly to the Quality Assurance Performance Improvement Director to be used for indentifying trends in practice and patient care. The Quality Assurance Performance Improvement Committee will analyze the frequency and causes of incidents and pursue measures to minimize recurrence through the active cooperation of facility staff, medical staff and administration. Statistical data and summaries will also be reported to the governing board at least quarterly.

D **Facility Actions:** Internal facility actions may be taken as a result of investigation and data compilation and will be in accordance with facility policies and procedures and bylaws of the medical staff bylaws and governing board.

IX PLAN

A copy of the current risk management plan will be included in the employee policy manual and the bylaws of the governing board and medical staff. The plan will be reviewed and approved by the governing board annually and whenever amended. All amendments will be submitted to the Kansas Department of Health and Environment Risk Management Program Director for approval prior to implementation.

X PRIVACY AND CONFIDENTIALITY

Any person or committee performing any duty pursuant to this plan shall be designated as a peer review officer or committee pursuant to KSA 65-4915 and amendments thereto.

All reports and records made pursuant to KSA 65-4921 et seq, and amendments thereto, shall be confidential and privileged. Such reports and records shall not be subject to discovery, subpoena or other means of legal compulsion for their release to any person or entity and shall not be admissible in any civil or administrative action other than a disciplinary proceeding by the appropriate state licensing agency.

No person in attendance at any meeting of an executive or review committee or a medical care facility or of a professional society or organization while such committee is engaged in the duties imposed by KSA 65-4923 shall be compelled to testify in any civil, criminal, or administrative action, other than a disciplinary proceeding by the appropriate licensing agency, as to any committee discussions or proceedings.

No facility personnel, medical staff member or board member shall disclose information concerning reportable incidents except to their superiors, administrator, risk manager, the appropriate facility and medical staff committee or the licensing agencies, unless authorized to do so by the risk manager.

XI INTERFERENCE WITH RISK MANAGEMENT PROCESS AND RETRIBUTION FOR REPORTING

A Attempts by any employee of the facility or medical staff member to inhibit or prevent any other employee or medical staff member from reporting what they believe meets the definition of an incident, shall not be tolerated, and will result in reprimand, suspension, or termination of any person who tries to inhibit or prevent.

B Pursuant to KSA 65-4928, the facility will not discharge or otherwise discriminated against any employee for filing an incident report, or the facility may be subject to civil suit by the employee for so doing. Retaliation for reporting is not appropriate.

XII RETENTION OF RM DOCUMENTS

Incident reports, investigation tools, minutes of risk management committees, and other documentation of clinical analysis for each reported incident shall be maintained by the facility for not less than one year following completion of the investigation.

XIII RESOURCE ALLOCATION

Facility X will provide necessary resources for a full-time risk manager (if part time, specify number of hours) and other staff support necessary to fulfill the risk management program.

The facility administrator will designate individuals as necessary to complete data and to provide other identified support for the risk manager.

RISK MANAGEMENT PROGRAM

Governing Body

Facility name and address: Facility X
800 Main Street
Hometown, Kansas 65432

Risk Management Committee Members:

Jane Doe RN, Risk Manager and Swing Bed Director, Chairperson

Joe Click, Radiology Director

Sue Stick, Lab Director

Robert Pace, Physical Therapy Director

Vickie Streeter, Outpatient Services Director

Clara Barton RN, Director of Nursing

William Right, Quality Assurance Performance Improvement Director

Medical Staff Executive Committee Members:

Dr John Jones, Chief of Medical Staff, Chairperson

Dr Phil Heal, Chief of Surgery

Dr Roberta Gas, Chief of Anesthesiology

Dr Seth Young, Chief of Obstetrics

Dr Theresa Quick, Chief of Emergency Medicine

Non-voting member: Health Information Director and Risk Manager

Risk Manager:

Jane Doe RN, Risk Manager and Swing Bed Director

APPROVAL PAGE

Risk Management plan reviewed and approved by:

_____	_____
Chairman of the Governing Board	Date
_____	_____
Administrator	Date
_____	_____
Chief of Medical Staff	Date
_____	_____
Risk Manager	Date

Revised 04/17

Appendices Reporting Forms

<Insert Reporting Forms Here>